TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2a Hospital outpatient department services and community hospital outpatient clinic.	The following services are covered: 1. Physician 2. Optometric 3. Psychology 4. Podiatric 5. Physical therapy 6. Occupational Therapy 7. Speech pathology 8. Audiology 9. Acupuncture 10. Laboratory and X-ray 11. Blood and blood derivatives 12. Chronic hemodialysis 13. Hearing aids 14. Prosthetic and orthotic appliances 15. Durable medical equipment 16. Medical supplies 17. Prescribed drugs 18. Use of hospital facilities for physician's services 19. Family planning 20. Respiratory care 21. Ambulatory surgery 22. Dental	Refer to appropriate service section for prior authorization requirements. Refer to Type of Service "5a Physician's Services" for other requirements.

* Prior authorization is not required for emergency service.

**Coverage is limited to medically necessary services